CHATTANOOGA-HAMILTON COUNTY HEALTH DEPARTMENT
PATIENT REGISTRATION INFORMATION

PLEASE PRINT DATE_____

_____

PATIENT LAST NAME FIRST MI BIRTHDATE

_____ STUDENT? FULL PART-TIME

OTHER LAST NAME (S) USED MAIDEN NAME (IF APPLICABLE) CIRCLE

_____

MAILING ADDRESS CITY STATE ZIP CODE

_____ _____YEARS **MAY WE CONTACT YOU?** YES NO

HOME PHONE WORK PHONE EDUCATION CIRCLE

_____

PATIENT'S SOCIAL SECURITY NUMBER RACE SEX MARITAL STATUS

DATE OF ENTRY INTO COUNTRY _____ COUNTRY OF ORIGIN _____

ADDITIONAL FAMILY MEMBERS TO BE SEEN TODAY

_____

PATIENT LAST NAME FIRST MI BIRTHDATE

_____

OTHER LAST NAME (S) USED RACE SEX SOCIAL SECURITY NUMBER

_____

PATIENT LAST NAME FIRST MI BIRTHDATE

_____

OTHER LAST NAME (S) USED RACE SEX SOCIAL SECURITY NUMBER

RESPONSIBLE PARTY

_____

LAST NAME FIRST MI RELATIONSHIP SOCIAL SECURITY NUMBER

CHARGES ARE BASED ON YOUR FAMILY SIZE AND YOUR TOTAL MONTHLY INCOME. WE MUST HAVE THE INFORMATION BELOW TO DETERMINE YOUR BILL TODAY, OTHERWISE FULL CHARGES WILL BE APPLIED.

FINANCIAL AND INSURANCE INFORMATION MONTHLY INCOME (SELF AND SPOUSE) BEFORE TAXES**

HOUSEHOLD EMPLOYMENT INCOME	_____
CHILD SUPPORT/ALIMONY	_____
UNEMPLOYMENT COMPENSATION	_____
RETIREMENT	_____
SUPPLEMENTAL SECURITY INCOME (SSI)	_____
TENNESSEE ASSISTANCE FOR NEEDY FAMILIES (TANF)	_____

TOTAL _____ NUMBER IN FAMILY _____

TENNCARE/MEDICARE OR PRIVATE INSURANCE CO. _____

ID NUMBER _____ EFFECTIVE DATE _____

_____

SIGNATURE OF RESPONSIBLE PARTY

"WORKING TOWARD A HEALTHY COMMUNITY"

NC-81 (Rev. 4/06)

PERMISSION FOR SERVICES

CHATTANOOGA-HAMILTON COUNTY HEALTH DEPARTMENT
921 E. THIRD STREET
CHATTANOOGA, TN 37403

NAME_____BIRTHDATE_____

ADDRESS_____
Street City State Zipcode

PERMISSION FOR HEALTH SERVICES

‹ I , the undersigned , do hereby give my consent for the Chattanooga-Hamilton County Health Department to perform screenings, examinations and/or provide treatments for disease, referrals to other health care practitioners and the necessary follow-up to myself, my child, or ward. I understand that I have the right to refuse any and all treatment and medications. I also acknowledge the release of medical information necessary and appropriate to prevent and control communicable disease, comply with required audits, and medical record review. Furthermore, I authorize the release of medical or other information necessary to process a claim to TennCare, Medicare, or any health insurance plan. This authorization will expire three (3) years after the date it is signed.

‹ Initial and date _____

PERMISSION FOR DENTAL SERVICES

‹ I, the undersigned, do hereby give my consent for any dental care for myself, my child, or my ward, which the examining dentist feels is necessary, including x-rays, fluoride treatments, restorations, and extractions. I also give my consent for the use of local anesthetics, nitrous oxide-oxygen mixture, and other drugs as deemed necessary by the dentist. I understand that I have the right to refuse any and all treatment and medications. I also authorize the release of dental information necessary and appropriate to provide care for myself, my child, or ward. Furthermore, I acknowledge the release of any dental, medical, or other information necessary to process a claim to TennCare, Medicare, or any health insurance company. This authorization will expire three (3) years after the date it is signed.

‹ Initial and date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

‹ I acknowledge that I have received a copy of the Chattanooga-Hamilton County Health Department Notice of Privacy Practices.

‹ Initial and date_____

SIGNATURE_____DATE_____

RELATION TO PATIENT_____(complete if other than patient)

WITNESS_____DATE_____